

Request for a Business Auto Quote

Requested Effective Date:		Agent:		Agency:	
Agent email:				Agent Phone #:	
Insured Name including DBA:					
Type of Business: <input type="checkbox"/> Individual <input type="checkbox"/> Corporation <input type="checkbox"/> LLC <input type="checkbox"/> Other _____					Yrs in this Business
Location	Address		City	State	Zip Code:
Mailing					
Garaging					

Description of Business:		<input type="checkbox"/> For Hire/Profit <input type="checkbox"/> Not For Hire <input type="checkbox"/> ● Other _____			
Range of Transport: <input type="checkbox"/> Interstate <input type="checkbox"/> Intrastate		Are Filings Required: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Radius of ● operation		Please list major Metropolitan Areas traveled through or into:			
●-1●● miles: <input type="checkbox"/> 1●1-3●● miles: <input type="checkbox"/>		_____			
3●1-5●● miles: <input type="checkbox"/> 5●1+ miles: <input type="checkbox"/>		_____			
Type of Operation:					
<input type="checkbox"/> Towing <input type="checkbox"/> Repo (<input type="checkbox"/> Yes <input type="checkbox"/> No) <input type="checkbox"/> Private Carrier/Business Auto <input type="checkbox"/> Dump <input type="checkbox"/> Wrecker <input type="checkbox"/> Contractor <input type="checkbox"/> Food Delivery <input type="checkbox"/> Specialized Deliver <input type="checkbox"/> Trash/Refuse/Waste (non hazardous) <input type="checkbox"/> ● other (describe): _____					

Insurance History			Years Prior Insurance Under Business Name: _____		
Has any insurance company canceled or nonrenewed your policy in the last 3 years?					
<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain in Comments section below.					
From	To	Ins. Co	Policy Premium		

Insurance Loss Experience		Amount of Loss	Bodily Injury Involved?	Driver Involved
Date of Loss	Description of Loss			
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	

Driver Information		Must be completed on all drivers. (Include owner)				
Driver Name		Date of Birth	License Number	State	#Yrs Driving Similar Equip	CDL or Chauffers License?
1	●wner:					
2						
3						
4						
5						

Driver Information Continued (last 3 years)				
	Date of Hire	#Violations	# Accidents	Details (Accidents are considered at fault unless report showing not at fault is submitted)
1				
2				
3				
4				
5				

Schedule of Autos to be Insured				All units you own or are leased to you must be scheduled and insured if filings are to be made.			
#	Model YR	Trade Name/Make	Model/Body Style	Vin (17 Digit)	Gross Vehicle Weight	Current Stated Value Excl. Elec. Equip	Max Radius
1							
2							
3							
4							

Additional information:
 Personal Use: Yes No If yes, explain and provide % of personal use:

Coverages and Limits <input type="checkbox"/> Med Pay: \$ <input type="checkbox"/> Physical Damage Deductible: \$ <input type="checkbox"/> In-Tow/On-Hook Coverage Limit: \$ Ded: \$	Auto Liability: CSL \$ UM/UIM Limits: \$ PIP Coverage Limit: \$ ** Additional Supplements may be needed to quote these coverages.	<input type="checkbox"/> ** Non-Owned Auto: # of Employees: <input type="checkbox"/> ** Hired Auto Cost of Hire: If Any Basis <input type="checkbox"/>
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Comments:



IL: il@jmwilson.com Fax: 847-427-9931 P: 800-241-7080
 IN: in@jmwilson.com Fax: 317-566-1696 P: 800-538-4796
 M●: mo@jmwilson.com Fax: 816-561-3331 P: 800-507-8656
 MI: mitrans@jmwilson.com Fax: 269-327-9856 P: 800-666-5692
 ●H: ohtrans@jmwilson.com Fax: 614-890-6333 P: 800-388-8178
 WI: wi@jmwilson.com Fax: 608-327-9856 P: 800-695-0059
 SR: srtrans@jmwilson.com Fax: 269-327-9856 P: 800-595-0063

Public/Business Auto New Venture Questionnaire

Insured Name including DBA: _____

Garaging Location: _____

Website address: _____

- 1 Number of years ins this business?
 - 2 Have you ever operated under another name? Yes No
If yes, explain in the comment section below.
 - 3 What are the insured's plans for growth? Does the insured anticipate obtaining/adding units in the current year? If yes, explain in comment section below. Yes No
 - 4 Does anyone other than the named insured own the power units listed? Yes No
If yes, explain in the comment section below.
 - 5 Have you ever had your own authority? Yes No
If yes, explain in the comment section below.
 - 6 Number of years Chauffer's experience:
 - 9 Date original CDL or Chauffer's license was issued:
 - 10 Name of coach builder that stretched any units over 120" stretch:
 - 11 If you were a company driver or previously lease to a motor carrier, provide the prior employment information:
- | Year | Company or Motor Carrier
City, State & Phone # | Claims or Accidents/Losses
During the past 3 years |
|------|---|---|
| | | |
| | | |
| | | |

Additional Comments: _____

The undersigned, an authorized representative of the insured shown above, represents that all information contained in this document is true and accurate in content. You authorize investigation of all statements contained herein and the references and employers shown above to give us and and all information concerning my previous employment and any pertinent information they may have and release the company from all liability for any damage that may result from utilization of such information.

Signed: _____

Date: _____

Title: _____